MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

March 2005

DATA SYSTEMS & ANALYSIS

Maryland Trauma Physician Services Fund

Staff completed processing on-call and uncompensated care applications for payment from the Fund covering the period of July through December 2004. Approximately 240 physicians received uncompensated care payments and all seven Level II and III Trauma Centers received on-call payments. MHCC distributed approximately $2.7 million in uncompensated care and on-call payments. This total is net after MHCC applied $330,258 in adjustments identified by the Fund's auditor, Clifton-Gunderson, from the initial audit. This is the first application period where adjustments identified by the auditor were applied to uncompensated care and on-call payments. Staff anticipates that applicants will receive funds issued by the *Office of the Comptroller* around the end of March. Staff mailed applicants disbursement reports summarizing trauma services approved for payment under the Fund. The Fund has a balance of $10 million, net of on-call and uncompensated care payments for the first half of FY 2005. Medicaid has not yet submitted an accounting of Medicaid spending payable by the Fund. Medicaid reports that spending attributed to trauma has been far less than estimated.

Clifton-Gunderson completed reviews of the seven trauma centers' on-call applications during the April 1, 2004 through June 30, 2004 reporting period. Trauma centers will be notified in March of any adjustments identified during the audit process.

MHCC staff is preparing to an RFP that will identify a contractor to audit on-call and uncompensated care applications. The RFP will be submitted to the Department of Budget Management (DBM) in the middle March. Staff hopes to release the RFP by the end of April, but the release is contingent on DBM approval. The current incumbent is Clifton-Gunderson of Towson. Maryland.

The Assessment Data Base

The MHCC staff launched a Web site to collect the financial information needed for computing the MHCC annual assessment. Insurance carriers and nursing homes were informed of the application and the procedures for submitting information on March 1st. The new site will streamline submission of financial data and increase efficiency of the MHCC staff as redundant entry of the paper forms will be eliminated. Although insurance carriers and nursing homes will still be required to submit a paper check for assessment fees, future enhancements envision implementing an automated clearing house (ACH) feature that would allow the regulated organizations to submit an electronic transaction to the Treasury. MHCC staff implemented the ACH feature in licensure renewal applications at the Board of Physicians and the Board of Pharmacy. After the first two weeks of operation, results are promising (Table 1). Organizations have until April 30, 2005 to submit their data. Hospitals are exempt from completing the on-line survey as HSCRC provides MHCC with hospital financial data for the assessment.

Table 1 – MHCC ASSESSMENT SURVEY
Date: 3/14/2005

Web Tracking		
No. of Companies /Facilities	**Insurance**	**Nursing Homes**
Number	908	257
Survey Required	908	250
No Survey Required	0	7
Completion of Required Surveys		
Completed	7	46
Not Completed	901	204

Internet-Based Re-Licensure Application for the Maryland Board of Physicians
MHCC staff is working with the Board of Physicians (MBP) to further develop MBP's Internet-based re-licensure application. In 2002-04, the MHCC staff developed and refined the renewal application and released the product to the MBP. This year, MHCC staff will add a credit card feature to the application. Currently the application accepts ACH transactions and standard paper checks. Many private physicians have stated they would use a credit card function, despite the higher transaction costs. Board of Physicians will begin renewing licenses in July.

Medical Care Data Base
The updates and enhancements to this year's *Data Submission Manual (Manual)* were completed in February. The staff made two changes in the submission manual that will allow use of the data for additional policy related studies. First, beginning with the June 2005 submission, MHCC will ask carriers to identify services provided via consumer directed health plan (CDHP) products. The 2004 data will serve as baseline to measure future growth of these products. Secondly, payers will be required to fully code place of service (POS). Recent submissions have shown significant variations in the coding on POS among payers. Staff is beginning to monitor use of urgent care centers and emergency rooms by the insured population, but variations in coding among the payers make tracking changes in utilization difficult. Payers will be asked to distinguish emergency department from the hospital outpatient and urgent care centers as place of service. Staff intends to provide payers with a hard copy version of the Manual around mid-March. The *Data Submission Manual* is also available at the MHCC Web site.

Institutional Review Board Action
The MHCC Institutional Review Board (IRB) approved a request from a researcher at the Johns Hopkins University School of Medicine for access to encounter and drug data from the MCDB for a study on Immune Thrombocytopenic Purpura (ITP) in Maryland. ITP is a platelet disorder in which autoantibodies directed at platelet surface antigens leads to platelet destruction. The IRB's recommendation for approval is contingent on the Johns Hopkins School of Medicine's IRB either approving the request or granting an exemption. Staff anticipates presenting the IRB's recommendation to the Commission at the March meeting.

Ambulatory Surgical Survey
MHCC awarded the 2004 Freestanding Ambulatory Surgery Survey development contract to Metro Data of Hunt Valley, Maryland. In early March, the 375 ambulatory facilities were notified that the survey was available for use. Ambulatory surgical centers are required to complete an annual survey within 45 days from the notification date.

Cost and Quality Analysis

Practitioner Report
The staff will release ***Practitioner Utilization: Trends within Privately Insured Patients from 2002 to 2003*** at the March meeting of the Commission. The report, mandated under MHCC's enabling statute, examines payments to physicians and other health care practitioners for care provided to privately insured Maryland residents under age 65. The analyses are based on the health care claims and encounter data that private health insurance plans serving Maryland residents submit annually to the Commission as part of the Medical Care Data Base. A key objective of this report is to attempt to quantify the increase in professional services used by non-elderly privately insured Maryland residents. Among the principal findings:

- The major factors driving the 6 percent increase in spending was a 3 percent growth in services per patient and a 3 percent growth in the number of services per user. Payment rate increases of 2 percent accounted for a smaller portion of the growth. Offsetting these increases was a small decline (1 percent) in the number of users, a finding that is consistent with other MHCC reports released in the last 6 months.

- Average non-HMO payment rates to providers are about 2 percent above Medicare rates on average and HMO rates are about 3 percent lower. Private payments rates, relative to Medicare, were essentially unchanged from 2002, due to about a 1.5 percent increase in Medicare rates in 2003. Private payment rates have risen about 4 percent in the state since 1999. Maryland private payment rates probably rank in the bottom one-quarter of all states in terms of private sector payments relative to Medicare.

- The fastest-growing broad category of service was imaging. Simple imaging, advanced imaging (MRI, CAT, and Cardiac), and echography all increased more rapidly than the growth for all services. This pattern parallels the results that MHCC reported the last two years. However, fees for imaging declined from 1 to 3 percent depending on category of service and plan type. Since 2000, payments have increased by 65 percent for simple imaging, by 87 percent for advanced imaging, and by 55 percent for echography. Procedures, particularly major surgical procedures, were not a significant contributor to spending growth, although these services account for a significant portion of total spending.

Analysis of Screening Colonoscopies using the MCDB
The Center for Cancer Surveillance and Control at DHMH has requested that the Division of Cost and Quality Analysis provide estimates on the total number of colonoscopies in the State of Maryland, by county, on a quarterly basis for 2003. These results will used to monitor trends in colonoscopy screening in the state. The results will be presented at the CDC-sponsored conference, *Moving Colorectal Cancer Screening Forward: a Maryland Dialogue for Action*, to be held on Friday, June 10th, 2005. The conference will bring together major state policymakers that play a role in cancer screening initiatives.

EDI Programs and Payer Compliance

HIPAA Awareness

The MHCC's EDI/HIPAA Workgroup (Workgroup) met to identify strategies for increasing EDI adoption and HIPAA awareness among providers statewide in February. Over the next year the Workgroup is expected to provide staff with input on programs aimed at expanding EDI adoption and compliance with the Health Insurance Portability and Accountability Act of 1996, (HIPAA) Administrative Simplification regulations.

In January, staff notified 39 payers of the EDI reporting requirements. Designated payers have until June 30th to submit an EDI Progress Report. Staff intends to provide reporting payers with additional guidance documents for submitting their EDI Progress Report in March.

Staff updated the *Payer Internet Guide* to include new payer information on their provider Internet capabilities. The *Payer Internet Guide* was developed in August 2004 by staff with the assistance of the EDI/HIPAA Workgroup. The next release is scheduled for April and includes information relating to the Internet capabilities of six leading payers in Maryland.

Staff continued to work with dental providers and payers to produce a Dental EDI Fact Sheet that contains information relating to EDI dental transactions in Maryland. This information will be used by the Maryland State Dental Association and the Maryland Academy of General Dentistry to increase EDI activity among dentists. Dental EDI has historically trailed other health care providers. Staff intends to work with the two state dental associations to develop programs aimed at expanded EDI activity statewide. Staff toured the operations of a local dental electronic health network and discussed issues relating to expanding dental EDI.

Staff assisted Health Fusion, an electronic health network, which is interested in doing business in Maryland. Staff worked with Health Data Exchange (HDX) in completing their application for MHCC recertification. Staff is currently reviewing MHCC recertification documentation for Per Se Technologies with plans to make a final recommendation to the Commission at the April Commission meeting. Staff provided support to MYSIS in completing their MHCC and EHNAC candidacy status applications.

MHCC's HIPAA education and awareness initiatives continued throughout February. During the month, staff provided support to the following organizations:

- Anne Arundel Medical Center Practice Administrators
- Montgomery County Medical Association
- Software Unlimited
- Southern Maryland Hospital
- Frederick Memorial Hospital
- Maryland State Dental Association
- Maryland Chiropractic Association
- Salisbury Medical Group Management Association

E-Scripting Initiative

Staff supported EHNAC in making modifications to the E-Script Network Accreditation criteria. The criterion is currently posted on the EHNAC Web page for public comment. At the end of the comment period, EHNAC will formally adopt the E-Script accreditation program. Plans now call

for the organization to begin accepting e-scripting network accreditation applications in July. Over the next few months staff plans to educate e-scripting networks interested in the Maryland market on the accreditation/certification criteria.

PERFORMANCE AND BENEFITS

Benefits and Analysis

Small Group Market
Comprehensive Standard Health Benefit Plan (CSHBP)
On January 31, 2005, Commission staff mailed the survey material to all carriers participating in the small group market in Maryland to collect their annual financial data. The deadline for carriers to submit these data is April 1st. Staff will complete an analysis of the survey results, including number of lives covered, number of employer groups purchasing the CSHBP, loss ratios, average premiums as they relate to the ten percent affordability cap, etc. Staff will present these findings to the Commission in the spring.

Limited Benefit Plan (LBP)
In 2004, the Maryland General Assembly enacted SB 570, requiring the Commission to develop a Limited Benefit Plan (LBP) that will be available to certain small employers beginning July 1, 2005. Along with meetings with interested parties and a public hearing, staff worked with Mercer, its consulting actuary, as well as CareFirst and MAMSI, to develop alternative proposals that meet the statutory requirement of pricing the LBP at 70% of the cost of the CSHBP as of January 1, 2004. Staff presented the proposals, along with draft regulations, at the December 2004 meeting. The Commission approved the draft regulations for publication. The draft regulations were published in the *Maryland Register* on February 4, 2005 for the 30-day comment period. One public comment was received. The Commission will be asked to provide final approval of the regulations at its March meeting. Upon approval, the regulations will be implemented effective July 1, 2005.

Website
Commission staff have developed a website to be used as a guide for small business owners in their search for health insurance for their employees. This "Guide to Purchasing Health Insurance for Small Employers" is available on the Commission's website at: www.mhcc.state.md.us/smgrpmkt/index.htm. Commission staff have developed a bookmark describing information available on the small group website. This bookmark has been distributed to various interested parties, such as small business associations, Chambers of Commerce, the Maryland legislature, the Department of Labor, Licensing and Regulation, and the Department of Business and Economic Development. As a result of the initial mailing, many of these organizations have requested additional bookmarks to distribute to their constituents.

Health Savings Accounts
In December 2003, Congress passed the Medicare Prescription Drug, Improvement and Modernization Act, authorizing the offering of health savings accounts (HSAs) in conjunction with high deductible health plans. These plans became available to small employers in Maryland effective July 1, 2004 if carriers elect to develop and market them. The CSHBP regulations have been modified to accommodate this offering during the transition period (for contracts sold between July 1, 2004 and December 31, 2004) and may have to be further modified to

accommodate additional federal guidelines in the future. Aetna began offering an HSA-compatible PPO product in Maryland's small group market in August 2004.

The National Association of Health Underwriters has added a new section to its website entitled, "Understanding Health Savings Accounts." The link also has been linked to the above-mentioned Commission website for small businesses. (http://www.nahu.org/consumer/HSAGuide.htm)

Evaluation of Mandated Health Insurance Services (2004)
Pursuant to the provisions of §15-1501(f)(2) of the Insurance Article, *Annotated Code of Maryland,* Commission staff requested that members of the House Health and Government Operations (HGO) and Senate Finance Committees submit proposals for mandated health insurance services that they would like included in the annual evaluation. As required under current law, the Commission must evaluate all mandates enacted or proposed by the General Assembly and new suggestions submitted by a member of the General Assembly by July 1st of each year. For the 2004 report, three requests for mandate evaluation were submitted by members of the General Assembly: to evaluate wraparound mental health services for children; to evaluate air ambulance services; and to evaluate smoking cessation coverage. The 2004 final report was submitted to the 2005 Maryland General Assembly and is available on the Commission's website. The HGO and Senate Finance Committees were briefed on this report in January.

Legislative and Special Projects

Uninsured Project
DHMH, in collaboration with the MHCC and the Johns Hopkins School of Public Health, was awarded a $1.2 million State Planning Grant by the Health Resources and Services Administration (HRSA). HRSA is the federal agency that oversees programs to ensure access to care and improve quality of care for vulnerable populations. The one-year federal grant provides Maryland with substantial resources to examine the state's uninsured population and employer-based insurance market and to develop new models to make comprehensive health insurance coverage fully accessible to all Maryland residents.

Among the several activities, the grant has enabled DHMH and MHCC to conduct further analysis of existing quantitative data sources (Maryland Health Insurance Coverage Survey, MEPS-IC, and CPS), as well as collect additional data to help design more effective expansion options for specific target groups. In addition, focus groups with employers were conducted in order to better understand the characteristics of firms not currently participating in the state's small group market. A report summarizing the findings from the focus groups is available through a link on the Commission's website.

The grant team was awarded a one-year, no cost extension of the project timeline, with an interim report submitted to the Secretary of the Department of Health and Human Services (HHS) in November. DHMH has applied for another one-year, no cost extension to extend the grant activities to August 2005. During this period, DHMH will conduct a telephone survey of Medicaid recipients to clarify the discrepancy in data between the number of Medicaid enrollees listed in DHMH's administrative data and the number of Maryland Medicaid enrollees reported in the Census Bureau's Current Population Survey (CPS). MHCC staff is providing technical assistance. In addition to the Medicaid analysis, the remaining funding through the grant will be used for projects approved by the HRSA SPG administrative staff, such as (1) development of an outreach strategy for its Primary Care Waiver once it is approved by the Centers for Medicare and Medicaid Services (CMS); (2) provision of funding for the analysis of the Maryland data from the

Medical Expenditure Panel Survey – Insurance Coverage (MEPS-IC), as well as the layout design and printing of the report (Note: MHCC is taking the lead in overseeing this project); (3) provision of funding for modeling fiscal and other impacts of a statutory requirement that high-income individuals who do not purchase health insurance be subject to an income tax penalty; and (4) funding for an update to the Interim Report to HRSA and the Final Report due to HRSA in August 2005. The grant's supplemental funds that remain from the previous year total approximately $100,000 and are under the purview of the Department of Health and Mental Hygiene (DHMH), not the Maryland Health Care Commission.

The final report is due to HHS at the end of the contract period. T he final report must outline an action plan to continue improving access to insurance coverage in Maryland. A report outlining the options to expand coverage to Maryland's uninsured was delivered to the members of Maryland's General Assembly in February 2004.

Patient Safety

Chapter 318 (HB 1274) of 2001 requires the Commission, in consultation with DHMH, to study the feasibility of developing a system for reducing preventable adverse medical events. A Maryland Patient Safety Coalition was initiated by the Delmarva Foundation and served as the Commission's sounding board for its activities related to patient safety. Three workgroups were formed: one to look at issues related to systems changes to be recommended; one to address current regulatory oversight and reporting requirements; and a third to discuss issues related to a proposed Patient Safety Center.

Commission staff released a request for proposal (RFP) to designate the Maryland Patient Safety Center (MPSC). The Maryland Hospital Association and the Delmarva Foundation have been selected to jointly develop and operate the MPSC. Both organizations have agreed to fund the Center for the first three years. The Health Services Cost Review Commission recently approved funding the MPSC during its first year ($762,500) through increased hospital rates. This amount is equivalent to 50% of the anticipated Center expenses, and will be used in conjunction with funding from the MHA, Delmarva, and Maryland hospitals. A press conference announcing the designation was held on June 18, 2004 in Annapolis. Under the terms of the agreement, the Delmarva Foundation and the Maryland Hospital Association are required to submit semi-annual reports updating the status and progress of the MPSC. The first report was delivered to the Commission staff in November and provided to the Commissioners at the last Commission meeting. This report provides information on the MPSC's activities to date, including the arrangement of the governing structure and the staff; the formation of the advisory board, the recruitment of hospitals and nursing homes; data collection and analysis; and education (e.g., collaboratives). The First Annual Maryland Patient Safety Conference is scheduled for Thursday, March 31st.

Study of the Affordability of Health Insurance in Maryland

The 2004 General Assembly enacted SB 131/HB 845, requiring the Commission and the Maryland Insurance Administration to conduct a study of the affordability of private health insurance in Maryland. An interim report, including findings and recommendations from the study, was mailed to the Commissioners. At the January 11, 2005 Commission meeting (via conference call) the Commission approved the interim report for submission to the Maryland General Assembly. Copies of the report were distributed to the Senate Finance Committee and the House Health and Government Operations (HGO) Committee at briefings on January 25th and January 26th, respectively. The interim report also is posted on the Commission website. The final report is due by January 1, 2006. The HGO and Finance Committees were briefed on the Affordability study at the end of January.

2005 Legislative Session

The 2005 Maryland General Assembly session commenced January 12 and adjourns April 11, 2005. MHCC staff has briefed the House Health and Government Operations Committee and the Senate Finance Committee on the Commission reports related to the small group market, mandated benefits, the report on Health Insurance Coverage in Maryland, the State Health Care Expenditures report, and the Interim Report on the Study of the Affordability of Health Insurance in Maryland (SB 131/HB 845). As of Friday, March 11th, staff has reviewed numerous bills, including 45 bills that directly affect the Commission's activities or are related to the Commission's mission. As of March 11, 2005, the Commission has taken a position or written letters of information/support/concern on 45 bills.

Facility Quality and Performance

Nursing Home Report Card

Chapter 382 (SB 740) of 1999 requires the Commission, in consultation with the Department of Health and Mental Hygiene and the Department of Aging, to develop a system to comparatively evaluate the quality of care and performance of nursing facilities. The web-based Nursing Home Performance Evaluation Guide is available through the Commission's website. The Guide includes a Deficiency Information page, data from the Minimum Data Set (MDS) and the MHCC Long Term Care Survey, as well as an advanced search capability, allowing consumers to search by facility characteristics and certain services.

In addition to indicators selected by the Maryland Nursing Home Performance Evaluation Guide Steering Committee, the site also includes the quality measures that are reported on the CMS Nursing Home Compare Website. Inclusion of this information on the Maryland site provides consumers with the ability to obtain comprehensive information in one location. The CMS measures were enhanced in January 2004 and are now consistent with the consensus recommendations from the National Quality Forum. The fourteen enhanced quality measures build on the original ten measures and provide additional information to help consumers make informed decisions.

Evaluation of the Nursing Home Guide

The Commission contracted with the Lewin Group to perform an evaluation of the nursing home performance evaluation guide. The purpose of this procurement was to conduct interviews with consumers and discharge planners to test the Guide in real-time with respondents using computers. The objectives of the study included: (1) evaluating consumer/professional usage, preferences, and understanding of the Guide; (2) determining ease in navigating through the website; (3) developing recommendations to improve the Guide; and (4) recommending outreach strategies to increase the utilization of the Guide.

All interviews were completed and a draft report was presented to the Nursing Home Performance Evaluation Guide Steering Committee for review and comment. The Lewin Group presented the final report to the Commissioners. The Nursing Home Report Card Steering Committee is in the process of prioritizing the recommendations.

Nursing Home Patient Satisfaction Survey

The Commission also contracted for the development of a nursing home patient satisfaction survey or the recommendation of an existing tool that provides information for consumers that can be integrated into the Maryland Nursing Home Performance Evaluation Guide by: (a) reviewing and summarizing existing nursing home satisfaction surveys and implementation

processes developed by the federal government, state agencies, other public organizations and private entities or organizations; (b) discussing the cost of administration for each approach; (c) identifying the strengths and weaknesses of the various approaches and indicating whether a similar approach is feasible in Maryland; (d) designing or modifying a survey tool; and (e) proposing a plan for administering the tool including estimated implementation costs and timelines.

A report that included a review of the literature and interviews with various states was presented to the Nursing Home Report Card Steering Committee during its January 2004 meeting for review and comment. The Nursing Home Performance Evaluation Guide Steering Committee met on March 26, 2004 and recommended that we proceed with the self-administered family satisfaction survey and also pursue a pilot project in collaboration with AHRQ to pilot the Nursing CAHPS tool for resident satisfaction.

The RFP for the family satisfaction survey was released on November 1, 2004. The deadline for receipt of proposals was extended to December 8, 2004. The Evaluation Committee has reviewed all documents and requested best and final offers. The selected proposal will be taken to the Board of Public Works for final approval in April.

Nursing Home Patient Safety

The Steering Committee began discussion of nursing home patient safety measures that are appropriate for public reporting. The Committee was presented with an overview of the literature and activities and other states as well as a list of ten common patient safety measures. The Steering Committee agreed that the Commission should begin with reporting health care facility-acquired infections and staffing as two indicators of safety.

Hospital Report Card

Chapter 657 (HB 705) of 1999 requires the Commission to develop a performance report on hospitals. The required progress report was forwarded to the General Assembly. The Commission also contracted with the Delmarva Foundation, in partnership with Abt Associates, to: (1) analyze hospital data to develop appropriate indicators for inclusion in the Hospital Performance Evaluation Guide, and (2) design and execute a consumer-oriented website for the Guide. The initial version of the Hospital Performance Evaluation Guide was unveiled on January 31, 2002.

A new edition of the Hospital Guide was released during a press conference held on May 16, 2003. The revised Guide included quality of care information specific to the treatment and prevention of congestive heart failure and community acquired pneumonia including individual hospital rates, the state average, and the highest rate achieved by a hospital for each of the measures. The first sets of conditions were selected from the Joint Commission on Accreditation of Healthcare Organization's (JCAHO's) ORYX initiative, which collects quality of care information from hospitals in a method designed to permit rigorous comparisons using standardized evidence-based measures. The quality measures data were updated in June 2004 to include information from the 3rd and 4th quarter of 2003. During this update, the time period for administering an antibiotic for pneumonia within a timely manner was reduced from 8 hours to 4 hours. Additionally, the percent of patients receiving the recommended pneumococcal vaccination prior to discharge was added to the site.

The latest edition to the Hospital Guide features the addition of six new acute myocardial infarction (AMI) treatment measures. Additionally, trend information for the past two years was publicly reported for the first time. This latest version of the guide marks an important step in

providing information on differences emerging in hospital practices and identifies a trend that, in general, shows hospitals' quality measures have improved. For instance, the provision of appropriate smoking cessation counseling for heart failure patients rose from 45 percent in 2002 to 81 percent in 2004. The number of people receiving appropriate discharge instructions for heart failure nearly doubled. The release also reveals that some hospitals have room for improvement. In the case of pneumonia care, many hospitals performed the recommended blood test more than 90 percent of the time while others perform the test less than 70 percent of the time. This edition of the Guide was released during a press event on January 27, 2005 prior to the Commission meeting.

The Guide also continues to feature structural (descriptive) information and the frequency, risk-adjusted length-of-stay, risk-adjusted readmissions rates for 33 high volume hospital procedures, and obstetrics data which were updated in December 2004 for admissions occurring during calendar year 2003.

Redesign and Expansion of the Hospital Guide

The Commission contracted with the Lewin Group to perform an evaluation of the hospital performance guide. The purpose of this procurement was to conduct interviews with consumers, primary care physicians, and emergency department physicians to test the Guide in real-time with respondents using computers. The objectives of the study included: (1) evaluating consumer/professional usage, preferences, and understanding of the Guide; (2) determining ease in navigating through the website; (3) developing recommendations to improve the Guide; and (4) recommending outreach strategies to increase the utilization of the Guide.

All interviews were completed and a draft report was presented to the Hospital Performance Evaluation Guide Steering Committee for review and comment. The Lewin Group presented the final report to the Commissioners.

The Hospital Report Card Steering Committee met in July 2004 to begin the redesign process. During this meeting, the Committee approved four major areas of expansion- inclusion of composite measures and mortality data, use of different symbols, and development of a hospital compare function.

The Committee met on October 12, 2004 at the University of Maryland in Baltimore County for a discussion of detailed redesign issues, facilitated by TechWrite, Inc., a subcontractor of Delmarva Foundation. The Committee agreed to a design that would specify portals for three major users- prospective patients, hospital leaders, and hands-on providers. Understanding that each audience has different information requirements, the portals would serve as an entry point to targeted content, presentation and language. Website changes were prioritized and the redesign work is currently underway.

Patient Safety Public Reporting Workgroup

The goal of the Workgroup is to explore patient safety indicators that can be obtained from administrative data and then progress to other measures. The workgroup reconvened in October 2004. Staff presented preliminary AHRQ patient safety indicators and the workgroup recommended the availability for private viewing by hospitals while the Committee evaluates which indicators will be appropriate for public reporting. Additionally, staff will begin to analyze indicators related to mortality.

Recommendations for publicly reporting healthcare acquired infections were made. The plan proposes to expand the Guide to include information on health care associated infections (HAI) –

including both process and outcome measures. MHCC will work with the CDC, CMS, Patient Safety Center and the Maryland Office of Epidemiology and Disease Control Programs on infection definitions, measurement and collection. The MHCC Commissioners approved the release of a call for public comments regarding the proposed HAI public reporting plan at its November 23rd meeting. The comment period ended December 7th with no comments precluding the data collection. However, facilities requested that a subset of the procedures be implemented initially to give hospitals the opportunity to gain experience with data collection and to ensure resource adequacy. Staff subsequently identified a subset of the measure which will be piloted with 2nd quarter data—knee arthroplasty, hip arthroplasty and colon surgery.

Additionally, the group has recommended that information regarding the availability of Intensivists in the ICU and progress toward computerized physician order entry (CPOE) be included on the Web site. The Committee members realize that there are varying definitions of CPOE and that some of the definitions may not be appropriate for use in Maryland at the current time; therefore, careful consideration will be given to components selected for reporting. Questions regarding Intensivists and CPOE were included with the hospital "Facility Profile Information" distributed near the end of October.

Staff will continue to work with the HSCRC, AHRQ, and others to produce data reports for committee review. Lastly, the workgroup recommended that the JCAHO patient safety measures be reported when they become available by either linking to the JCAHO report or adding the data to the Maryland Guide directly.

Patient Satisfaction Project

MHCC participated in a three-state hospital public reporting pilot project initiated by CMS. The Hospital Report Card Steering Committee served as the steering committee for the pilot. The Committee serves as the primary vehicle for obtaining input and consensus prior to initiating the state specific activities.

The Maryland Performance Evaluation Guide Steering Committee received a briefing on the pilot results during its January 27, 2004 meeting and agreed that Maryland should pursue the use of the tool to collect patient satisfaction data for the *Maryland Hospital Performance Evaluation Guide.* MHCC staff then met with representatives of CMS and AHRQ to discuss an additional pilot of the tool that will take place this summer. A proposal with a complete study design was submitted to AHRQ on April 6, 2004 to request permission to use the HCAHPS tool.

MHCC received approval to use the revised HCAHPS tool in another pilot that began in October 2004. MHCC received hospitals' submissions of four months of discharge data at the beginning of November 2004. Surveys were sent to the sample of patients drawn from the 47 acute care hospitals in Maryland. Pediatric and other specialty hospitals (e.g., cancer facilities) were excluded.

An average of 220 surveys per hospital were sent to the selected participants in an effort to obtain 100 completed surveys by mail or telephone. Discharges were classified as medical, surgical, or obstetrics services based on the DRG code. The surveys were randomly distributed across patients discharged from the hospital for medical, surgical, or obstetrics services (total=4,700 surveys for the state).

The survey process concluded in February 2005 and responses are currently being analyzed. Preliminary findings indicate a fifty percent response rate.

Other Activities
The Facility Quality and Performance Division is also participating in the planning process for a new Health Services Cost Review Commission (HSCRC) Quality Initiative designed to evaluate and recommend a system to provide hospitals with rewards and/or incentives for high quality care. Staff attends the HSCRC Quality Initiative Steering Committee meetings on an ongoing basis. The draft report of the HSCRC Steering Committee was also presented to the Hospital Performance Evaluation Guide Steering Committee on January 27, 2004 for review and comment. Since that time, HSCRC developed an implementation framework that was presented to the Commissioners during the January 2005 meeting.

Ambulatory Surgery Facility Report Card
Chapter 657 (HB 705) of 1999 also requires the Commission to develop a performance report for Ambulatory Surgery Facilities (ASFs). The Commission developed a web-based report that was also released on May 16, 2003. The 2003 data have been added to the site.

The website contains structural (descriptive) facility information including the jurisdiction, accreditation status, and the number and type of procedures performed in the past year. The site also includes several consumer resources. The site is currently being updated to provide search and compare functionality, as well as show volume data over a three year period.

An ASF Steering Committee was convened to guide the development of the report and consists of representatives from a multi-specialty facility, a large single specialty facility, an office based facility, a hospital based facility, and a consumer representative. An exploratory meeting was held with a subset of this group in January 2003. Subsequently, the Steering Committee provided input on several of the proposed web pages including a consumer checklist, glossary, and list of resources. Staff continues to research recent developments in performance measurement in ambulatory surgery.

HMO Quality and Performance

Distribution of 2004 HMO Publications

Cumulative distribution: **Publications released 9/27/04**	**9/27/04 to 2/28/05**	
	Paper	**Electronic Web**
Measuring the Quality of Maryland HMOs and POS Plans: 2004 Consumer Guide **(22,000 printed)**	20,101	Visitor sessions = 1,771
2004 Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland **(600 printed)**	600	Visitor sessions = 863
Measuring the Quality of Maryland HMOs and POS Plans: 2004 State Employee Guide— 50,000 printed and distributed during open enrollment		

8th Annual Policy Issues Report (2004 Report Series) –

Released January 2005; distribution continued until January 2006

Maryland Commercial HMOs & POS Plans: Policy Issues (900 printed)	609	Visitor Sessions: 170

Distribution of Publications

With full efforts devoted to audit and survey activities, outreach remained limited to fulfilling order requests submitted by public libraries in response to January's outreach activities. In response to January's order request to all libraries, more than 850 copies of the *Consumer Guide* were sent to replenish their depleted inventories.

During February, applications were prepared for submission to the Library of Congress to copyright each of the 2004 HMO publications.

2004 Performance Reporting: HEDIS Audit and CAHPS Survey

HEDIS Audit Activities

Key audit functions are underway by HealthcareData.com (HDC), the audit contractor. Division staff serves as an integral part of the audit team through engagement in many of the evaluation activities. Like last year, staff will participate in the onsite phase of the audit. To prepare for this segment, staff has completed four out of six reviews of the baseline assessment tool (BAT) submitted by plans for which MHCC staff will give direct oversight. HMOs use the BAT to supply information about their data systems and HEDIS data reporting structures and processes. Regular communications throughout the month about findings identified during document review helped lead auditors structure their interview strategy. Additional follow-up included requests to HMOs with missing or incomplete documentation. This level of interaction among all participants in this project continues to support improvements in data completeness and accuracy.

The first onsite visit was held February 15-17, 2005 in Hartford, CT for CIGNA Healthcare. The audit proceeded with no major issues. The auditor will provide MHCC with a list of all outstanding issues in the monthly auditor status report. Division staff did not attend the onsite visit.

The audit onsite visit for MAMSI (MD IPA, OCI) was held March 3-4, 2005. In preparation for the onsite visit, the HMO was asked to provide additional documentation for various vendors providing services. The majority of this information was provided in time for the audit and was reviewed by the lead auditor and MHCC staff members attending the audit. The audit proceeded well; however, several follow-up issues must be resolved.

The next site visits are March 17-18, 2005 for Aetna and March 22-23, 2005 for Coventry of DE. This phase of the audit will conclude in April.

HDC remains on track for completing all tasks within the specified timeline.

Consumer Assessment of Health Plan Study (CAHPS Survey)

As a check on the survey process, HMO Division staff was seeded for each of the four scheduled mailings to sampled members from each plan. To date, two waves of mailing have been

completed. The Myers Group (TMG), the CAHPS survey contractor, has adhered to the schedule. As a new contractor with this Division, TMG has worked closely with staff in the development of all survey materials and related start-up tasks. Minor process and quality issues with printed materials remain a focus of staff and, where possible, changes will be made this year. Otherwise, staff will provide TMG with recommendations for improvements during a debriefing in late spring.

To compare the distribution of sampled members selected from the HMO and POS products to the distribution of the total enrolled population, TMG produced a report of distribution frequencies. With one exception, sample frequencies demonstrate that enrollees in each product are proportionally represented in the survey sample for six plans. The remaining plan will investigate the discrepancy identified through this analysis.

Proposed Changes to HEDIS 2005

The HMO Quality and Performance Division received notification of NCQA's public comment period asking for commentary on the proposed changes to HEDIS 2006. Eight new measures have been proposed with five applicable to commercial products: Use of Spirometry Testing in the Assessment and Diagnosis of COPD , Pharmacotherapy Management of COPD Exacerbation, Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication, Appropriate Treatment for Adults with Acute Bronchitis, and Annual Monitoring of Patients on Persistent Medications. Changes have also been proposed for eight measures currently included in HMO reporting requirements for 2006. The suggested changes integrate the latest clinical guidelines developed by leaders in various medical fields and guidelines developed by federal agencies. Staff will examine the changes and comment as appropriate by the March deadline.

Report Development Contract-Procurement

A request for proposals (RFP) for HMO Report Development work for the next contract period (2005 - 2007, with an extension period of one additional year through May 31, 2008) has been submitted to the Department of Budget and Management for approval.

HEALTH RESOURCES

Certificate of Need

Staff issued twelve determinations of non-coverage by Certificate of Need (CON) review during January. In licensure-related activities, determinations of non-coverage by CON review were issued to Kensington Nursing and Rehabilitation Center of Montgomery County to temporarily delicense fourteen beds at the facility, to Fairfield Nursing Center of Anne Arundel County to relicense five temporarily delicensed beds, and to Randallstown Center, to temporarily delicense 45 beds. Also, CCF beds that have been temporarily delicensed at three Genesis facilities in Baltimore County for approximately 18 months have been deemed abandoned, because of the extenuated and non-specific nature of the proposed plan for their redevelopment: these beds were located at Catonsville Center (4 beds), Loch Raven Center (10 beds), and Cromwell Center (3 beds).

During the last month, Staff also issued to the planned Fox Hill Continuing Care Retirement Community in Montgomery County a determination of non-coverage by CON requirements for the establishment of a comprehensive care facility with twenty-six beds for the exclusive use of members of the retirement community, contingent on the issuance of a "preliminary certification" as a CCRC by the Maryland Department of Aging.

In addition, Staff issued authorizations for waiver beds for two health care facilities: Chesapeake Youth Center, a 54-bed residential treatment center for adolescents in Dorchester County, may increase its licensed capacity by five beds, and the Transitional Care Unit at Good Samaritan to increase the licensed bed capacity by three skilled nursing facility beds. The James Vogel Ambulatory Surgical Center in Baltimore County has received a determination of non-coverage by CON requirements to establish an ambulatory surgery center with one sterile operating room and one non-sterile procedure room.

Staff issued a determination of non-coverage by CON review to Mercy Medical Center for the closure of the four-bed psychiatric service at the hospital, following the required 45-day notice to the Commission and the holding of a public informational hearing in mid-December. Staff conducted a first-use review of Good Samaritan Hospital's renovations to the hospital for the addition of three mixed-use operating rooms, and the expansion of the PACU from nine to eighteen beds, which received CON approval from the Commission in November 2003.

In early March, Staff will be submitting an updated and extended schedule of dates for the submission of Certificate of Need applications to the *Maryland Register* for publication. The previous schedules appeared in the October 15, 2004 edition of the *Register*.

Acute and Ambulatory Care Services

Changes to COMAR 10.24.12, the State Health Plan for Acute Hospital Inpatient Obstetric Services, were approved as final regulations by the Commission at the January 27, 2005 Commission meeting. Supplement 1 became effective on March 1, 2005.

Long Term Care and Mental Health Services

Staff of the Long Term Care Division is representing the Commission at the Maryland Department of Aging's Continuing Care Advisory Committee. The first meeting of the Advisory Committee was held on February 7, 2005 and the second meeting was held on March 8, 2005. The group also divided into subcommittees to study specific issues in more detail. Staff will attend the New Issues Subcommittee, which will hold its first meeting on March 16, 2005.

The Maryland Hospice Survey 2004 is online and available for hospice providers to enter their data. All hospices in the state were notified by February 9, 2005 and the survey was available for online data entry as of February 21, 2005.

An updated public use data set for the 2003 Maryland Hospice Survey has been developed and is now online. This version eliminates some extraneous variables and provides a dataset that is simpler and easier to use.

Specialized Health Care Services

The State Health Plan for Cardiac Surgery and Percutaneous Coronary Intervention (PCI) Services (COMAR 10.24.17) requires a hospital without on-site cardiac surgery to obtain a waiver to provide primary PCI services. Primary PCI is used to treat certain patients with acute myocardial infarction. The hospital requesting the waiver must demonstrate the ability to comply with all requirements for primary PCI programs without on-site cardiac surgery as specified in COMAR 10.24.17. The procedure for a hospital to obtain a primary PCI waiver from the Commission includes the collection and reporting of a uniform data set. In January 2005, the Commission began a pilot test of the data set recommended by the Primary PCI Data Work Group. The Commission has received final feedback from three of the seven hospitals that are testing the data collection forms: North Arundel Hospital, St. Agnes HealthCare, and Sacred Heart Hospital.

COMAR 10.24.17 requires that hospitals providing elective PCI services have cardiac surgical services on-site. This chapter of the State Health Plan also includes provisions for the Commission to consider a request for a waiver from its policies for a well-designed, peer-reviewed research proposal. On January 29, 2005, Thomas Aversano, MD sent to the Commission a proposal to study elective PCI at hospitals without on-site cardiac surgery. In a letter accompanying the proposal, Dr. Aversano stated that he and his colleagues have submitted the proposed elective angioplasty study to other states (New Jersey, Georgia, Ohio, Connecticut, Alabama, and Illinois) for their consideration as well. The Commission's staff has contacted those states to discuss regulatory process and requirements related to the proposed study.

The Commission collects quarterly survey data to monitor the availability and utilization of acute inpatient rehabilitation services provided by licensed special rehabilitation hospitals in Maryland. Completed surveys are due 45 days after the end of each quarter. Fourteen of the fifteen hospitals have submitted data for the fourth quarter of calendar year 2004. On February 28th, St. Paul Computer Center provided to the Commission case-mix data showing the distribution of rehabilitation cases in calendar year 2004, which the Commission's staff forwarded to the facilities for their review. Staff also provided the reporting facilities with summary data for the third quarter of 2004.

The Commission also collects quarterly survey data to examine current utilization and project future utilization of bone marrow and stem cell transplant programs in the Maryland and Washington regional service areas. The Maryland region consists of Baltimore City and the counties of Maryland, excluding Charles, Montgomery, and Prince George's; the Washington region includes those counties, plus Washington, D.C. and Northern Virginia. Six of the seven regional centers (including one federal center) have submitted data for the fourth quarter of calendar year 2004. The submission of calendar year 2004 data by the program at George Washington University Hospital is still pending.